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RECENT REFORMS IN THE IHS

The IHS has restructured since 1995 as a result of the first stakeholder-driven design initiative, which recommended organizational changes that shaped how IHS looks today. Before making plans for the future, it is wise to examine the past. This section reviews important changes that IHS has made in recent years to get the job done effectively and efficiently.

Administrative layers downsized

The reference time frame for this Administration's restructuring goals begins in 2002. Members of the RIW believe changes in the Indian health care system prior to 2002 must be considered. Looking back, the IHS has already downsized and redirected FTEs to front line programs.

In looking at the long-term trends (see Figures 4.1, 4.2, and 4.3), it is clear serious reorganization began in the mid-1990s. Administrative layers at the IHS Headquarters and Area Offices were reduced by more than half. The charts on the next page show that IHS has made prudent use of its resources and has redirected savings from administrative downsizing to program services. Because workforce data for tribal health care programs is unavailable, the trends will understate the degree of restructuring since 1995. The addition of tribal workforce data, if available, would augment the upward trend evident for the front-line workforce and draw even greater contrast with the sharp declines at IHS.

The FTE reduction in IHS management layers has been significant and has implications for the extent of additional restructuring that is prudent and practical. The IHS has achieved downsizing during the past 6-8 years and its administrative functions are now about as lean as can reasonably be expected.

As part of the 1995-97 redesign of IHS, Indian leaders specified that IHS' organizational structure should be streamlined and duplicate and unnecessary offices be consolidated or eliminated. Before the redesign, the IHS Headquarters had over 140 individual organizational elements in 8 operational divisions. Today, IHS Headquarters has 40 organizational units aligned into 3 operational divisions. The IHS Headquarters reduced by 100 organizational units and 5 operational divisions. See Chart 4.4: IHS Headquarters Streamlined.

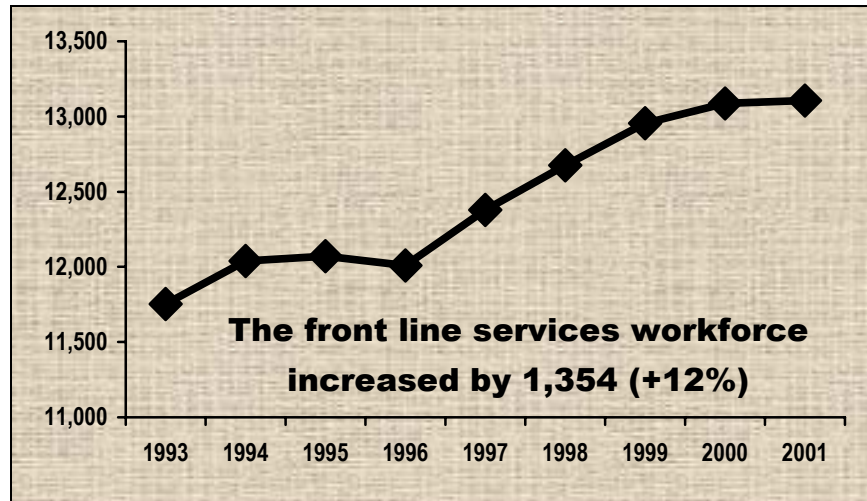


Figure 4.1, Front-line workforce was increased by 12 percent

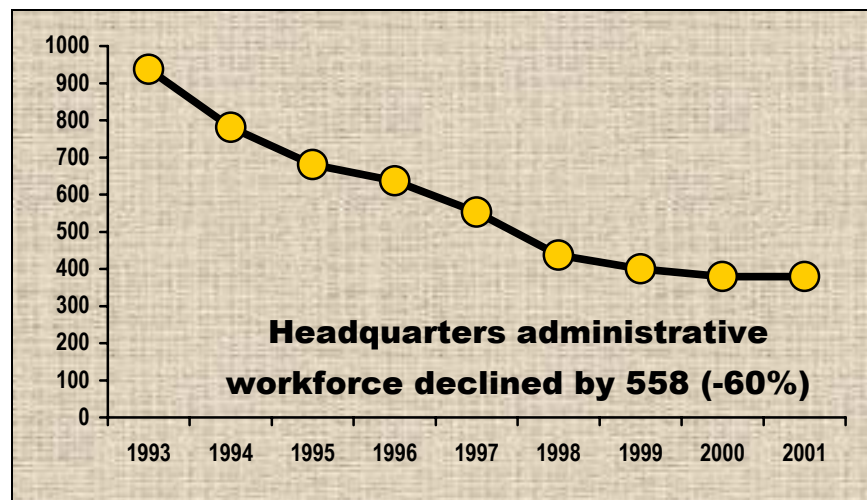


Figure 4.2, HQ ranks were reduced by more than half

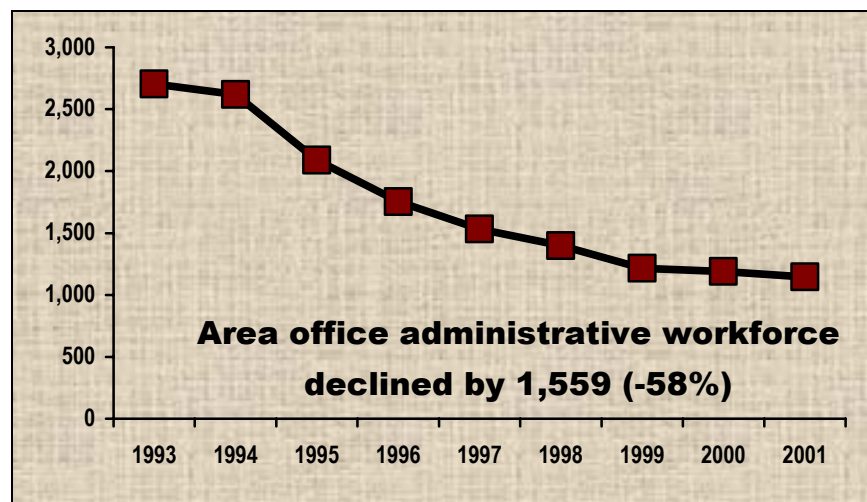
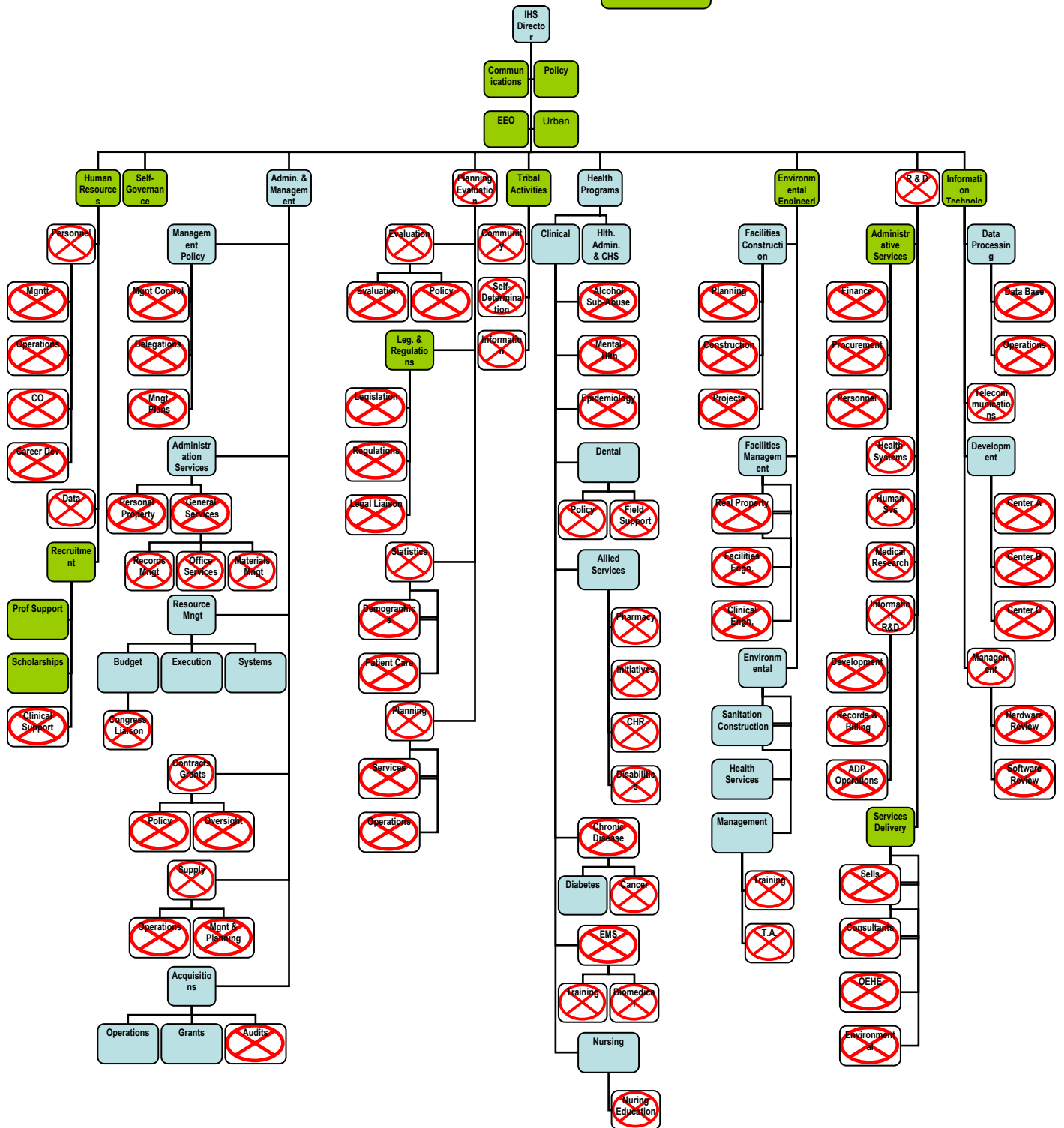
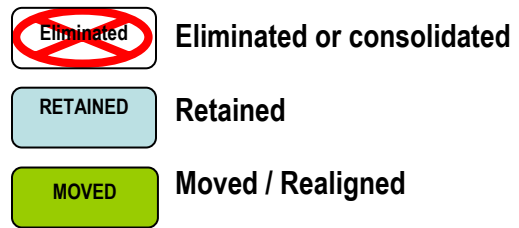


Figure 4.3, Area ranks were reduced by more than half

IHS headquarters was reorganized and streamlined in 1997.



Equally important to the Administration's goals are changes stimulated in IHS by transferring programs and resources to Tribes. By FY 2002, more than half of the IHS budget had been transferred to Tribes. Both IHS front line health care programs and administrative support programs were transferred to tribes through self-determination contracts and compacts. During the last ten years no other HHS agency has experienced the same level of downsizing pressures as those experienced by the IHS.

Downsizing and restructuring of IHS administration will continue as additional Tribes take over IHS functions through self-determination contracts and compacts. The IHS cannot absorb the FTE cuts specified in the FY 2003 IHS budget and simultaneously downsize FTEs required to transfer programs to Tribes over the next few years. The pace and magnitude of the combined reductions are of serious concern to the RIW because of the increased risk of disruptions of services.

Moreover, transfers of FTEs and resources from the IHS appropriation to other HHS appropriations are of great concern. Tribes have the right to contract and compact for IHS resources. Transferring resources and FTEs out of the IHS will diminish these rights. As a consequence, Tribes will have fewer resources available to operate the health programs. The RIW is opposed to FTE and resource transfers that detract from Tribal rights and potential operating resources.

The FTE and resource consolidations proposed by the HHS will actually diminish resources and services to Indian people. This is counter-productive to the Administration's goal to eliminate health disparities for American Indians and Alaska Natives. Health care resources and services must be increased to American Indians and Alaska Native.

Progress Despite Inadequate Resources

Despite the challenges and inadequate resources, Indian health has made progress in achieving its goal to improve the health of American Indians and Alaska Natives. Since 1973, Indian life expectancy has increased by 12.2 years. Mortality rates for American Indians and Alaska Natives have decreased significantly in many areas since 1973. Percentage-wise, the successes are reductions in death rates for:

Tuberculosis	reduced 79%
Gastrointestinal Disease	reduced 91%
Maternal Deaths.....	reduced 68%
Infant Deaths	reduced 58%
Unintentional Injury.....	reduced 56%
Pneumonia and Influenza	reduced 52%
Homicide	reduced 40%
Alcoholism	reduced 37%
Suicide	reduced 23%

Figure 4.5, Reductions in Indian Death Rates Since 1973

Build on Progress

Much more must be done to achieve the goal to eliminate the lingering disparities in Indian health status and resources. In this report, the RIW members identify the steps leading to a long-range vision when Indian people do not experience health disparities and the Indian health care system has enough resources. The first step is to review the IHS mission for achieving that long-range vision.

Revised Mission, Goals, and Foundation

It is important to periodically review whether the organization's mission still defines its work and whether its goals still best describe the desired outcomes. The RIW members agreed that the IHS mission must include environmental health because to American Indians and Alaska Natives wellness is a state of harmony and balance among mind, body, spirit, and environment. If the environment is unhealthy, the state of wellness is compromised.

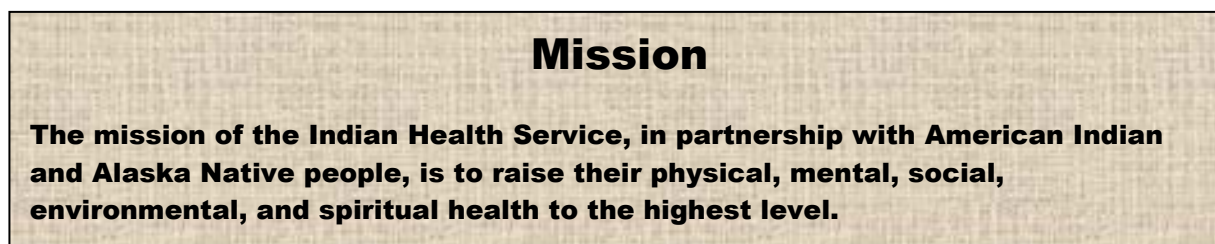


Figure 4.6, Proposed Mission

The IHS should retain the existing goal for providing health services to Indian people and add a goal for eliminating health disparities between American Indians and Alaska Natives and the general population.

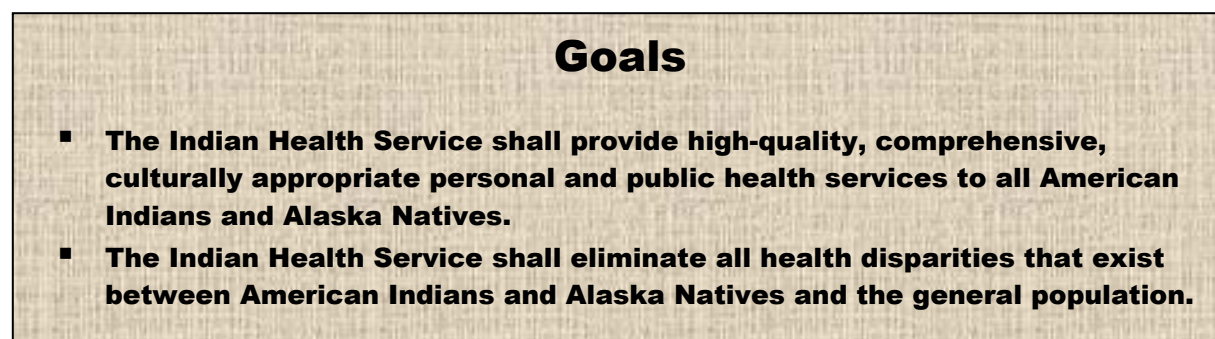


Figure 4.7, Proposed Goals

After considering the existing foundation statement, the RIW revised the language to highlight Tribal sovereignty, Trust Responsibility of the Federal Government, and government-to-government relationship between Tribal and Federal Governments.

Foundation

The United States has a unique legal and political relationship with American Indian and Alaska Native Tribes as set forth in the U.S. Constitution, treaties, statutes, Presidential Directives and Executive Orders, and court decisions. These legal instruments create a Federal Trust Responsibility to American Indians and Alaska Natives. This trust responsibility includes, but is not limited to, the protection of the inalienable right to Tribal self-governance and the provision of social, medical, and educational services for American Indians and Alaska Natives. The Department of Health and Human Services shall honor and uphold its Federal Trust Responsibilities and the inherent sovereign rights of American Indians and Alaska Natives.

Figure 4.8, Proposed Foundation

The proposed mission, goals, and foundation statements are the best overall definitive statements for guiding the IHS during the next five years.

- 4.1 Adopt the proposed foundation, mission, and goal statements to replace the existing statements.